Medicare Learning Network
MLN Matters
CMS CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 3094
MLN Matters Number: MM3094
Related CR Release Date: February 6, 2004
Effective Date: October 1, 2004
Implementation Date: October 1, 2004
Transmittal #: R95CP

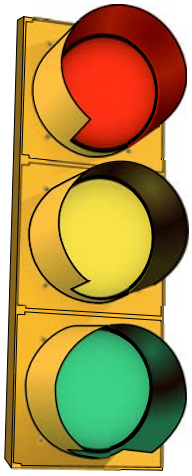
Elimination of the 90-day Grace Period for Billing Discontinued ICD-9-CM Codes

Note: This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

All physicians, practitioners, and suppliers who use ICD-9-CM Codes in billing Medicare carriers and Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed



STOP – Impact to You

Medicare systems will begin enforcing HIPAA standards on October 1, 2004, requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is provided.

CAUTION – What You Need to Know

Physicians, practitioners, and suppliers should be aware that CMS is instructing carriers and DMERCs to eliminate the 90-day grace period for billing discontinued ICD-9-CM diagnosis codes effective October 1, 2004.

GO – What You Need to Do

Adopt the new codes in your billing processes effective October 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of your claim.

Background

Medicare has previously permitted a 90-day grace period after the annual October 1 implementation of an updated version of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. This grace period gave physicians, practitioners and suppliers time to become familiar with the new codes and learn about the discontinued codes.

During this 90-day grace period (October 1 through December 31 of each year), physicians, practitioners,

and suppliers could use either the previous or the new ICD-9-CM diagnosis codes. For claims received on or after January 1, the updated ICD-9-CM codes were required to be used, and claims received with discontinued diagnosis codes were rejected as Returned Unprocessable Claims (RUCs).

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires the use of national/medical code sets that are valid at the time that the service is provided, and ICD-9-CM is a national/medical code set.

Therefore, the Centers for Medicare & Medicaid Services (CMS) can no longer allow a 90 day grace period for physicians, practitioners and suppliers to learn about the discontinued ICD-9 codes.

Providers can view the new, revised, and discontinued ICD-9-CM diagnosis codes at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/ on the CMS web site. CMS updates this site annually after the updated diagnosis codes are published in the Federal Register, which usually occurs by May 1 of each year.

Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers and DMERCs will no longer be able to accept discontinued codes for dates of service after the date on which the code is discontinued.

This is a HIPAA compliancy issue.

Implementation

October 1, 2004, is the date on which Medicare's claims processing systems will be changed.

Related Instructions

The *Medicare Claims Processing Manual, Chapter 23, Section 10, Subsection 10.2 (Relationship of ICD-9-CM Codes and Date of Service)* has been revised. The relevant revisions to Subsection 10.2 are the following:

10-2 – Relationship of ICD-9-CM Codes and Date of Service

(Rev. 1, 10-01-03)

PM B-02-027 (CR-2108), B-03-063, B-02-064, B-03-002

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since ICD-9-CM is a medical code set, effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in Table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis code grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year. Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable. Physicians,

practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004. After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following web site: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/.

For more information about the relationship of ICD-9-CM diagnosis codes and dates of service, go to Chapter 23, available at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS web site.

To view the actual instruction issued by CMS to your Medicare carrier, please go to http://www.cms.hhs.gov/Transmittals/downloads/R95CP.pdf on the CMS web site.

For more information on HIPAA's rules that relate to claims submission, other transactions, and code sets, please visit http://www.cms.hhs.gov/HIPAAGenInfo/ on the CMS web site.